

# 2009 H1N1 Influenza Vaccine Consent Form (POV)



PANHANDLE HEALTH DISTRICT

8500 N. Atlas Road, Hayden, ID 83835 208-415-5180

## Section 1: Information Required to Receive Vaccine (please print)

PATIENT'S NAME (Last)		(First)	(M.I.)	PATIENT'S DATE OF BIRTH month____ day____ year____	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	PATIENT'S AGE	GENDER  M / F
ADDRESS				PATIENT/PARENT DAYTIME PHONE NUMBER:	
CITY	STATE	ZIP			
POV/CLINIC LOCATION:					

## Section 2: Screening for Vaccine Eligibility (Children age 9 and under require two doses of vaccine.)

If the patient has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination.

- ☐ Dose 1      Date received: month \_\_\_\_ day \_\_\_\_ year \_\_\_\_      Type (please circle):      nasal spray      shot
- ☐ Dose 2      Date received: month \_\_\_\_ day \_\_\_\_ year \_\_\_\_      Type (please circle):      nasal spray      shot

The following questions will help us to know if the patient can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

A. If you answer "NO" to all four of the following questions, the patient can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, the patient may still be able to get the 2009 H1N1 vaccine, but please contact your doctor to discuss your options.

	YES	NO
1. Does the patient have a severe allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the patient allergic to any of the following: gelatin, Gentamicin, Polymyxin, Neomycin?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the patient ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine the patient can get.

	YES	NO
1. Has the patient been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month ____ day ____ year ____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the patient on long-term aspirin or aspirin-containing therapy (for example, does the patient take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the patient have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the patient pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the patient have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>

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## Section 3: Consent

### CONSENT FOR VACCINATION:

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT to Panhandle Health District and its staff for me/the patient named at the top of this form to be vaccinated with this vaccine.

Signature of Patient/Parent/Legal Guardian \_\_\_\_\_ Date: month\_\_\_\_day\_\_\_\_year\_\_\_\_\_

Relationship to child: \_\_\_\_\_

## Section 4: Permission to Release Information

I give permission to **enroll** the patient and to **transfer** the patient's immunization records into the **Idaho Immunization Reminder Information System (IRIS)** to ensure that this vaccination record is available to the patient, the patient's healthcare providers, childcare providers, and schools. I understand I may be asked for information that will help ensure the patient's records are accurate and will not be confused with another person's records, such as: mother's maiden name, gender, and child's eligibility for free vaccine. I authorize inclusion of all information into IRIS and redisclosure of this information from IRIS to authorized users. (The patient can still receive the vaccination if you do not authorize the release below.)

\_\_\_\_\_ Date: month\_\_\_\_day\_\_\_\_year\_\_\_\_\_

Signature of Patient/Legal Guardian / (Relationship to child)

## Section 5: Vaccination Record

### FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number (1 <sup>st</sup> or 2 <sup>nd</sup> )	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal		Sanofi MedImmune Novartis CSL		
2009 H1N1	/ /	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal		Sanofi MedImmune Novartis CSL		